HIT Policy Committee
Certification Adoption Workgroup
July 14, 2010

Presentation

Judy Sparrow – Office of the National Coordinator – Executive Director
Good morning, everybody, and welcome to the Certification Adoption Workgroup. There will be opportunity at the close of this call for the public to make comments. Just to reminder to workgroup members, please remember to identify yourselves when speaking. Let me do a quick roll call. Paul Egerman?

Paul Egerman – eScription – CEO
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Marc Probst?

Marc Probst – Intermountain Healthcare – CIO
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Rick Chapman?

Rick Chapman – Kindred Healthcare – Chief Administrative Officer/CIO/EVP
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Larry Wolf?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Adam Clark? Charles Kennedy? Scott White?

Scott White – 1199 SEIU – Assistant Director & Technology Project Director
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Latanya Sweeney? Steve Downs? Micky Tripathi? Joe Heyman?

Joseph Heyman – AMA – Board Chairman
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Carl Dvorak?

Carl Dvorak – Epic Systems – EVP
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
George Hripcsak?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Joan Ash?

Joan Ash – Oregon Health & Science University – Associate Professor
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
We also have Melinda Buntin and Ned Ellington on from ONC. Did I leave anybody off? Okay. Thank you. I'll turn it over to Paul Egerman and Marc Probst.

Marc Probst – Intermountain Healthcare – CIO
Thank you for those of you who could make this call today. I guess in advance, thank you so much for the e-mail exchange that we had a few weeks ago. That was very helpful and a lot of information.

About nearly a month ago we had the opportunity to talk to Melinda and Ned about some of the things they're doing in the space of certification and adoption. That came as a result of conversations Paul and I had with ONC about what should our workgroup's next steps be because I think we've had some interesting and successful recommendations go into ONC. We just thought we needed to keep the momentum up and clearly, the areas of certification have been hot recently, but adoption are just getting more and more timely and more for us to work on and discuss. So the hope was that we could understand better what Melinda and her team and Ned and his team and others are working on and then discuss the points that we sent out in the e-mail and see if we can prioritize a set of activities that we can work on to really help ONC. So we had this conversation last month. A lot is going on. If Ned and Melinda are ready; and I think it would be Melinda first and then Ned; we'd like to get into that.

I think Paul had a few things he wanted to say first, but again, thank you for being on the call. Hopefully, at the end of this we can determine our next steps.

Paul Egerman – eScription – CEO
First, I just want to echo what Marc said. I wanted to thank everybody who is participating in this call. This workgroup has done terrific work. I mean yesterday we had the final rules announced. To me it's all very exciting to see this happen.

If you look to see what was announced for meaningful use, the recommendations from this workgroup had an impact. I mean one of our recommendations related to sort of administrative simplicity. The original NPRM had a process where people had to count documents to figure out what percentage of their orders were being done electronically. That was an issue that, actually, I think it was Joe Heyman originally raised as to how many metrics there were and how hard it was to do the calculations. So we made a recommendation on that and they responded to that.

Certainly, what we recommended on certification. It's sort of like yesterday's news right now because everyone is very focused on what the meaningful use criteria turned out to be, which ... I think they did a really excellent job on that. But the certification is a little bit like yesterday's news, but we made some major changes on how certification occurred, so people should feel really good about how this all turned out. I think because we ... we also feel like there are other places where we could make contributions to the success of ONC. That's what we want to do.

Having said that, unless people have other comments, maybe the next step is to have Melinda and Ned give us the briefing of the ONC project.

Marc Probst – Intermountain Healthcare – CIO
Any comments from the workgroup members? I agree with you, Paul. It's pretty cool to see the process actually working out. I guess we can move on with Melinda.

Melinda Buntin – ONC – Director of Economic Analysis & Modeling
Thank you, all, for inviting me to speak. I'm Melinda Buntin. I am the Economist at ONC and Director of the new or relatively new Office of Economic Analysis and Modeling, whom the FACA committees have not heard much from to date. But we've been undertaking a range of activities that I would characterize as falling into four major categories, all of which I think are related to the agenda of this group. I'll list them and then I'll go through in more detail what we're doing in each of these areas.

We are participating in a number of data collection activities and in the analysis of the data. I will tell you about those efforts, again, in more detail. We're doing some modeling of adoption primarily focused on physicians right now, but we will be moving on to hospitals. We are undertaking a number of activities related to supporting and encouraging adoption. Then finally, my office is charged with performance measurement for ONC as a whole.

So, to go back to the first topic, data collection and analysis, the group is probably familiar with the fact that ONC has been supporting the past few years two national annual surveys. One is the IT supplement to the NAMCS Survey, which is done by the CDC, the National Ambulatory Medicare Care Survey and that surveys office based physicians. The other is an IT supplement to the AHA Survey. So we are continuing to support those surveys. We are updating them. We did update them and revise them this year in anticipation of meaningful use and we anticipate continuing to fund them in the future and adjust them as the stages of meaningful use progress so that we can track in a national sample providers' intent to apply to meaningful use and the stage of adoption that they might be currently at. Currently those surveys you may be familiar with because Dr. Blumenthal and his colleagues at Harvard wrote a set of articles about physician and hospital adoption that appeared in *The New England Journal* using them.

We also are undertaking a few new data collection and analysis efforts. One is that we have an agreement with CMS to be getting monthly data from them starting in 2011 on registration for and attestation of achievement of meaningful use so that we can use those data, analyze them, feed them back to programs like the REC Program that you'll be hearing from Ned about, and use them to inform our activities about who is applying for and who is achieving meaningful use, whether they're regional effects, specialty effects, etc.

We're also in the process of contracting for a number of new data sources. Among them we are hoping to procure data from the only national provider of electronic prescribing services. We're excited about that because that company tracks the source of prescriptions, whether they come through a standalone, e-prescribing module or through an EHR and if so, which EHR. That, again, is a national census really of

everyone who is e-prescribing, so we think that that will be very valuable data because the NAMCS Survey is only a relatively small sample of physicians, so a national census would be very useful to us.

We are also looking into designing a new, much more in depth survey of physicians' experience around adoption that I'll talk about in a few minutes, but that will be part of our data collection efforts.

Our second area that we've been focusing on is modeling adoption. We have a first-level model that we'll actually be presenting to the senior leadership team here at ONC later this week that is looking at physicians, looking at the rate at which the RECs need to be registering and moving physicians from purchase to adoption of a basic record to achieving meaningful use, how that would relate to historical trends and other things like that so that we can project out and benchmark ourselves against past trends and what we might be expecting to come out of some of our programs.

That model contains a number of assumptions, which are sort of, at this point, based on the opinions of a ... small group operating within my office and a few other people to ... presented preliminary versions of the model. We are in the process now of planning a conference, which I mentioned to Paul and Marc, for late summer that would present this model to an expert group and try and achieve some consensus around some of the model parameters so that they are based really on an expert consensus opinion rather than a smaller group at ONC's opinion. I had asked if this group would be interested in participating and I guess perhaps Judy can facilitate whether if there are people on the call, who would be particularly interested in participating we would be sure to invite you. It may be that the group as a whole wants to participate in this in some way and we'd be very open to that and eager to have your opinion reflected in what we're doing.

Our third area of activity is what I consider activities that support the adoption and meaningful use of EHRs. We have a review of the literature on the benefits of HIT. I presented preliminary versions of this review at HIMSS and at the Academy Health Conference this year. We have a plan to submit it in about three weeks. That's an ambitious plan, but we really want to get this out because what we've shown is that the literature that has come out over the past couple of years, since the last major review of the literature on HIT, which was ... by Gold ... in *Health Affairs* and came out, I think, in February of 2009; since that review, which covered the period through the beginning of 2007, there have been nearly 200 articles that have looked at various aspects of HIT and the vast majority of them have been positive and so we think that presenting this updated review in a peer review publication would be supportive of our efforts to get physicians to pay attention to EHRs and consider adopting them given the positive effects that they can have in a number of different domains.

We're also issuing a contract to look at the particular barriers that small and rural hospitals might have to adopting and particularly the financial barriers that we are requiring to result in the peer review publication and also a sort of user guide whitepaper for small hospitals on how they can basically maximize reimbursement if they adopt an EHR system, whether they are a critical access hospital or not, because we think there is a lot of misunderstanding out there about the fairly generous financial provisions that are actually in place, especially for the critical access hospitals.

Finally, as I mentioned earlier, we are in the process of designing and deciding whether we're going to do sort of an HHS partner or contract out for an in-depth study of the workflow implications of adopting an EHR. The idea here is that there's a lot of physician concern about adopting an EHR and what it might mean in the short to medium-term in terms of their productivity; lost time, need for additional support staff and things like that, but we have not found anything, other than small case studies that have examined the impact of EHR adoption on physician workflow and we don't know how that might be changing with tools to be better designed. So our plan there is to do a national and in-depth study of the cost and

benefits of adopting EHRs in physician practices with a focus, as the ROC focus is, on small and primary care practices, because we think that that is our area of primary focus.

Next year we're also looking at conducting a study, potentially in partnership with an organization like J.D. Power that would look at the usability of EHR systems. The idea there is that a barrier to purchase is physicians not having enough information with which to compare products. We don't want to get ahead of certification. We think we should wait for products to become certified and then start to try to assess them against the usability standard, but that's an area in which we're doing some exploration and we hope to either partner or contract that out next year.

Then finally, my office has responsibility for performance measurement for ONC. Our activities have really been focused around our public reporting to date. There are a number of different things that we have to report to Congress, that we have to report as part of the Recovery Act, and we are trying to systematically look at all of ONC's programs and develop measures that are appropriate to gauging their success, track them, report them as required by law, but we're also putting together what we think of as an ONC dashboard that would have both, a public and an internal face. The public face would report with more regularity than we are formally required to about how our programs are doing. Again, we think more information about the rate at which physicians and hospitals, for example, are registering for or attesting to meaningful use, are registering with the RECs, etc. will generate interest and enthusiasm.

Our final area of activity in the area of performance measurement, probably the thing that has the least relevance to this group, is that we are participating in a larger ONC effort to develop quality and efficiency measures. Our focus in the Office of Economic Analysis is obviously on the efficiency measures, but we think that that's important again because over the medium-term if we can develop measures of how EHR adoption or HIT adoption in general can effect efficiency, provider productivity, etc. it will generate more interest in HIT adoptions. We think that's an important part of our agenda and one that has not received as much attention as you would think, given public attention in general to reducing cost and waste in the healthcare system.

That's a brief overview of what we're doing in my office. I'm happy to take questions or have Ned jump in and tell you what's going on in the REC side and then we'll take questions.

Rick Chapman – Kindred Healthcare – Chief Administrative Officer/CIO/EVP
The question that I would have to your first point about data collection and modeling, and I'm sure you're doing this, but as you know, we're quite concerned about adoption and barriers to adoption, as you referenced in your support and encourage remark. But when you are collecting meaningful use stats and adoption stats do you have a provision to collect reasons or barriers or issues that people are having as well, either around process management or workforce or cost?

Melinda Buntin – ONC – Director of Economic Analysis & Modeling
That is an excellent question. In the past some of our surveys have collected information about barriers. The current versions of the surveys do not stress them, but the one area where my office is getting at this and it's certain to be a focus of the RECs as well and something that they will be doing, I'm sure, a lot of planning and mutual learning on is the workflow study that I mentioned. It's actually a little more complicated than I explained in my overview. We are planning it to be a stratified sample where we collect data from physicians, who haven't adopted, who are in the process of adopting and have already adopted EHRs about their experiences, perceptions, barriers, stumbling blocks, etc. So for the physicians, who haven't adopted, they would be tracked into a line of questions about why and what might help them to overcome their concerns about adopting.

Rick Chapman – Kindred Healthcare – Chief Administrative Officer/CIO/EVP
Okay. Well, the reason I bring it up is I think it would be very helpful at least to us as we consider potential future policy recommendations, to be able to at least understand the areas that seem to be not working as well as we want them to for both, physicians and hospitals. While a number of us in our different groups are focusing on the same thing, I think in your role it would be helpful to all, because then we might get calls for public hearings with the regional exchange centers or other groups to suggest ways they might help overcome those barriers. I think that would be most helpful to us on the committee.

Melinda Buntin – ONC – Director of Economic Analysis & Modeling
I would agree. If I take a step back I can also say that the study is still in the planning stages. It has many, many hurdles to go through and so I think there's a lot of work that this group could do long before we'll know the results of this study to identify barriers. I would hope that my group could assist by analyzing quickly, both the annual survey data and the meaningful use data as they come in to identify problem areas. So I think that that's an area in which we can collaborate and where if there were signals from the field that the committee or the workgroup was in a position to identify for us that would be helpful.

Rick Chapman – Kindred Healthcare – Chief Administrative Officer/CIO/EVP
Do you have any plan to do any similar type of monitoring of the certification process?

Melinda Buntin – ONC – Director of Economic Analysis & Modeling
We do not, but I would be interested in hearing more about what you mean by monitoring the certification process, because maybe I'm missing what your question is getting at.

Rick Chapman – Kindred Healthcare – Chief Administrative Officer/CIO/EVP
The same kind of question about any kind of problems people are having with that process, either getting to the vendor already or having the surveyor themselves, the process work. I think it's going to be the subject of our discussion later in this meeting today, so maybe we can follow up with you later.

Melinda Buntin – ONC – Director of Economic Analysis & Modeling
If you have suggestions for activities we should undertake that would be great.

Joseph Heyman – AMA – Board Chairman
Could I just ask you to repeat very briefly what the second item you discussed was, about something where the committee itself might want to participate?

Melinda Buntin – ONC – Director of Economic Analysis & Modeling
Sure. The second item was I was describing our efforts to model likely scenarios around adoption and attainment of meaningful use. So what we have right now is we have a very simple model where our input, our numbers of physicians in various groups, we look at historical trends and project them forward for purchase, adoption and then sort of more advanced adoption of records and we apply to it a number of different assumptions and scenarios about, for example, the difference that RECs will make in boosting adoption rates among small, primary care practices.

The model right now is ... fairly simple, but does contain a number of assumptions and so what we plan to do is convene a conference of experts to help us to vet what we think the key assumptions are about how adoption will play out over the next few years and to help us specify the parameters of the model in thinking about what are the important trends and how will they be different from past trends given, for example, the incentive payments, the RECs, unfolding ways to exchange data and the like. So that was something that when Judy identified that we should be working in tandem it seemed like an obvious place

for either the whole workgroup or members of the workgroup to participate in that conference and expert opinion gathering.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
So that's wonderful to hear. I mean is the goal really to predict or to explain? I mean where is your effort going? Explain to be able to go back and say, ~~–~~Look, we've seen this difference. The trend of adoption was this and now it's higher." Do we think that meaningful use incentives cause this amount of positive effect or is it to predict more, which I think is harder, especially since the program is two years and then there are penalties, so it's hard to say what's going to happen in the future?

Melinda Buntin – ONC – Director of Economic Analysis & Modeling
Well, at this point we actually are thinking about it as predict might be too strong of a word; you might be right with that; is to use it to build scenarios so that we understand the magnitudes of effects, the different parts of our programs we need to have in order for us to achieve goals. So you've probably heard people talk in workgroup meetings alike about goals for when we'll have hit the number of 100,000 providers achieving meaningful use. So the model can be used to say here are the types of things that we need to have happen here, the assumptions we need to make to hit that 100,000 provider mark. So it's really being used as a tool right now to help explore those issues.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
That's good. Then are you modeling? Like how much of this is public perception? Is it patients pushing their doctors to do it, which kind of makes the model a lot more complicated because it's all interconnected, as opposed to having individual units where you can model effects on them.

Melinda Buntin – ONC – Director of Economic Analysis & Modeling
Yes. Right now we don't actually. It's not a micro-simulation model in that we don't have the data actually from the CDC yet to have individual physician decision makers deciding whether to adopt, so it's really a much more aggregated model now, where we look at groups of physicians and what their historical trends have been broken down by specialty and practice size. So things like incorporating different amounts of patient demand are the types of things that we would like prioritized for our next generation model. That's part of the point of the conference is to say really what are the other forces that are going in here. What are their likely effects? How do we build them into the model going forward?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
And last, do we have experience? Like what other transformative IT things have been modeled successfully, like the adoption of the Web or the adoption of on-line purchasing, that kind of thing? Was that modelable and is this one similar to that?

Melinda Buntin – ONC – Director of Economic Analysis & Modeling
I've looked into a bunch of those types of models and categories of models around people using marketing, for example, and other areas. They are, in a sense, incorporated into our thinking about this model, but there's almost a unique storm around EHRs, so I'm hesitant to use some of those methods that really rely on extrapolating from past trends, trying to figure out what you could think of as a tipping point in the adoption curve, because I think what we have going on right now is not as if, for example, we've introduced a single technology and there will be early adopters and regular adopters and laggards, like you might project with an iPhone or something like that.

We have technology that's constantly changing. We have a very complex technology to adopt. We have vendors, for example, coming on with zero cost products that are totally on-line. We have our meaningful use incentive payments and then we have what I, as an economist, think of as network externalities,

which are certainly true with the Web and what I mean by those is the more people who adopt and are in a position to exchange data the more valuable adopting and exchanging data becomes. Again, we've brought in that kind of thinking to the model, but I don't think – I haven't come across a model yet that's been used in another sector that we can perfectly transfer over to help IT given the number of things going on.

I also have a certain amount of humility in looking at people who try to apply those models to EHR adoption in the past and they haven't done very well.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Okay. That's good. I mean I agree with everything you just said. The closest analogy I could come up with was adoption of the Web, which was equally complicated and changing and many moving parts.

Melinda Buntin – ONC – Director of Economic Analysis & Modeling
Yes.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
So that's good.

Melinda Buntin – ONC – Director of Economic Analysis & Modeling
And I won't pretend that my review of this area has been exhaustive. If anyone comes across things they think would be useful I would be delighted to see it.

Paul Egerman – eScription – CEO
First I have an observation and then a question. My observation is as I listened to your modeling process the observation is that it doesn't include an evaluation of what I would call vendor readiness or vendor bottlenecks. The reason I say that is I had a meeting with the CEO of a very large vendor to acute care to hospitals of these systems and he told me he currently has an 18-month backlog. When a customer signs with him he doesn't even get started installing them for 18 months because he has so many contracts.

I look at somebody when they tell me they have an 18-month or a 2-year backlog and I figure that's got to have some impact.

Melinda Buntin – ONC – Director of Economic Analysis & Modeling
You are so right and that is the kind of thing we would love to incorporate. Now, I haven't heard about that on the physician side. I actually don't have a model of hospital adoption yet, but I did talk about patterns of physician and hospital adoption with my colleagues in the CMF Office of the Actuary when they were putting together the impact analysis for the rule that was released yesterday. I don't expect anyone to read the text of the impact analysis, which is quite impenetrable, but if you did you would see in there some comments about this very issue. My discussions with some consultants operating in the hospital field and the like led me to tell my colleagues and the actuaries out there about this type of backlog and they did try and incorporate that into their projections about meaningful use payouts that were included in the rule.

So again, if you hear about things on the physician side that are similar I would certainly want to hear them and think about incorporating them. When we get to hospital adoption I think that's extremely important.

Paul Egerman – eScription – CEO

That last comment leads me to my second question, which is how can this workgroup be helpful to you in your work.

Melinda Buntin – ONC – Director of Economic Analysis & Modeling
Well, I would love it if some of you at least would participate in our conference. I would love it if the workgroup would— Actually, I don't want to violate some workgroup protocol here so, Judy, you can tell me what the best way to do this is. If any of you want to discuss what you think are these forces with me individually or with members of my team I'm happy to set up separate calls. There may be some other mechanisms that we could put in place so that I could use your collective wisdom and ability to collect more information from the field than I am able to myself to inform our efforts as they go along.

Paul Egerman – eScription – CEO
Our job is basically to help ONC be successful, so if we can do any of those things we should do it.

Melinda Buntin – ONC – Director of Economic Analysis & Modeling
Okay. Well, I will follow up with Judy then. I know she can help me come up with a strategy that will work given her experience with the other workgroups.

Judy Sparrow – Office of the National Coordinator – Executive Director
Great. I will do that.

Carl Dvorak – Epic Systems – EVP
I work with the EHR Association and they might be a good resource if you wanted to ask collectively about readiness and backlog. I don't think the 18 months is representative of all of the members, but they would probably be able to give you some sort of good understanding of any backlogs that may or may not exist in general.

Melinda Buntin – ONC – Director of Economic Analysis & Modeling
I want to say this in a way that comes off correctly. There is a lot of information that we would love to have from the field, but we are not permitted to collect information in a systematic way from more than nine parties due to the Federal Paperwork Reduction Act requirements. So if there's any outside data collection in any of these areas that you think are key that we could leverage that would be great. That might be something that I could brainstorm with you if your association would be collecting information of that type in the regular course of business; then we could certainly use it and it would be difficult for us to collect ourselves.

Carl Dvorak – Epic Systems – EVP
Okay. I'll work to follow up with you on that.

Melinda Buntin – ONC – Director of Economic Analysis & Modeling
Thank you.

Joan Ash – Oregon Health & Science University – Associate Professor
I wanted to follow up on Rick's question about the barriers and find out what plans there might be for identifying barriers to a hospital adoption or is that something you're not getting into for a while?

Melinda Buntin – ONC – Director of Economic Analysis & Modeling
Well, the only focus that we have right now is the project that I mentioned around the small, rural hospitals. So that is something we're in the process of writing a contract. The contractor will be conducting site visits to a number of hospitals to identify barriers. They're supposed to be site visiting the

hospitals that have successfully adopted and those who haven't and trying to put it together into a use guide type of thing for other hospitals that are considering adopting.

That is the only ongoing project I have right now. Looking forward though, I would think that some of the next things that would be on my staff's agenda would be in the more general hospital area. So if you have specific suggestions about how to think about hospital barriers, unique concerns, I would love to hear about them. I have to admit, I just don't have the bandwidth to be focusing on that at this moment.

Marc Probst – Intermountain Healthcare – CIO
Any more questions for Melinda? I guess we're on to Ned.

Ned Ellington – ONC – Director, HITRC Division
Good morning. Well, let me first off, again, like Melinda, thank you so much for inviting us to brief you on what we're doing. What I'm going to do is give you sort of a high-level overview, but just based on the interaction with Melinda I'm more interested in your asking questions and dialogue. I think that's a little more precise. Let me start off with a high-level overview and then sort of talk a little bit about the strategy of what we're going through with the REC Program.

First off, I am with the REC Program. We, inside the ONC, call that our OPAS office, our Office of Provider Adoption Support. Mat Kendall heads the office up. I direct a center called the HITRC, the Health IT Research/Resource Center. I will come back to that a little bit. Basically, if you're familiar with the original legislation, the FLA, the HTRIC and the RECs together are charged with not only going out and helping 100,000 small-doc operations ... select and successfully implement and meaningfully use EHRs. We're also creating what we call the National Learning Consortium.

Sort of on the tail of Melinda there, from a macro-economic perspective I view what we're about as really almost at a micro level. I've use the expression to many folks, —Yes we're out there helping implement EHRs, but we're also a living laboratory. This is exciting." I just can't really explain how exciting this program is to be able to have what I call a closed loop system from policy through implementation and immediately the feedback on what's working and what's not working in a systematic way because of this reason of existence in the program. So it's multi-faceted and it is fascinating.

Status: We have 60 RECs that have been awarded and cover most of the country. We still have a couple of places where we're plugging some holes as far as coverage. All 60 of our RECs are in business at varying stages. Some of them are existing organizations that have taken on the EHR project, if you will, to cover their area and so it's part of the portfolio of services.

Other RECs are consortiums, companies or organizations that have come together to actually accomplish this goal, so we have a variety of RECs in various stages of implementation. We anticipate that they're all up and running. Quite candidly, some of them are still staffing and still getting operations plans in and things like that. This summer we plan to hit where we're full speed ahead. We actually start next week a series of regional, two-day meetings for five weeks, five different regions. We will be spending much of the time at the regional meetings talking about meaningful use, as one could imagine, but we are also offering and will be providing a significant amount of training in the areas of outreach and education, implementation, meaningful use, etc. to the RECs. We chose to do regional meetings so people could reduce their travel out of office, etc. and actually to have smaller groups.

That's sort of a snapshot of from the outside what the REC system is about up and running and we're in business in various stages across the country, but open for business everywhere. Underneath that layer

is a strategy of how are we going to help the RECs be successful in helping their docs in the small hospitals be successful. That's where the HITRC comes in.

The HITRC's mission is to help accelerate the adoption and meaningful use of EHRs. As much of the discussion before and the work that you folks have done for years, we all know that there are a lot of barriers and one of the barriers is just the whole implementation process, the uncertainty in many, many areas, etc. So what we are attempting to do is to figure out how to mitigate some of that risk and part of that is through focusing and accelerating knowledge here. I've made a statement in many forums that the wonderful thing about our Regional Extension type of models is that you have the expertise of the local RECs and the richness of those. If we can leverage that across the system that learning is accelerated exponentially. To do that we created Communities of Practice; we've asked each REC to participate in a number of Communities of Practice, which pretty much were spelled out. Communities involving how do you help docs select vendors and the right solution for them, how do you do workflow redesign, all of the things that you folks talked about.

So we have these communities. They're up and we're bringing them together in both a virtual sense and a collaborative sense, as well as using the communities to understand the training needs of, first, the RECs and then the training needs and the technical assistance needs of their practice and the companies they're working with.

If you think about it from that perspective, part of the HITRC is to create a knowledge sharing network and implement that network in a fashion with the communities, pulling the information, working with each other, sharing best practices, sharing everything from collateral material that talks about case studies and docs that have more quality of work life because they entered an EHR, all of the things that one would think you would like to have. Then we asked them, —So what are we missing?"

When Melinda talked about the modeling, that's exciting and what we want to do is be able to say, —Here's what we're hearing from the field. Collectively the RECs made 1,000 calls last week on docs. Here's what we're hearing from the field." That's where we are now. I can go into much detail for those that are interested in the tools we're using, such as CRM tools or collaborative tools, etc.

But one thing I will touch on is sort of the vision for the HITRC though is, I said it's a research and resource center. Our focus right now is to help equip the RECs to be successful. As they become successful, in turn we learn best practices and we want to then turn those best practices; we want to validate those best practices empirically and we want to shift and expose those best practices to the broad public community through a public Web site. That's where we're moving. Ultimately, we want all of the knowledge, all of the tools, the training that we are developing and we're using or partnering with somebody, those that really are working well and thus we see some small doc operations to rural practices, etc. We definitely want to get that information out to the public and we will do that via the traditional channels, but specifically through a Web portal that will be open broad.

Perhaps I should stop there and ask for input on where you want me to go next. There are just so many things going on. I don't want to bore you with the myriad of things we have going on, so let me pause there and ask for direction on questions.

Rick Chapman – Kindred Healthcare – Chief Administrative Officer/CIO/EVP

One of the things that you said has peaked my interest. In these communities the knowledge sharing that you're setting up around what you are anticipating to be barriers, and you mentioned the implementation process and the things you put underneath of it from selection and workflow and all of the other components in my mind add up to what traditionally would be done by project management offices or

people of those capabilities or core strengths. I guess that that brought a question to mind. Are you all seeing any kind of problem with attracting and recruiting the type of skill sets that you need from the workforce to actually staff these Regional Exchange Centers?

Ned Ellington – ONC – Director, HITRC Division
You hit an Achilles heel quickly. Yes we are. It's a little too early to give you some real data on that. I think that in the extension type of business there tends to be the REC is modeled somewhat after other extension programs, although we have some uniqueness because of the healthcare environment, but it would be people that ... three types of folks in extension centers. One are groups of people who have been there and they're not ready to retire, but they've got a lot to give back and this is a great way for them to contribute back to the community. So we've certainly seen some of that in the RECs where people that have been around the industry for many years, this is worth going and spending another five more years in the workforce.

We also are seeing a lot of younger people that are eager to get in this area. They don't have the richness or the experience some of the vendors would like to have. They just haven't' been out there long enough and so that's the other end of the spectrum. That group in the middle, those 10-year to 15-year veterans that have been in HIT or even been in other implementation projects, right now they're a hot commodity. So although the RECs are able to recruit some of those we, through the HITRC are anticipating some specific .... We're actually creating a learning management system. We're going to implement a learning management system to help supplement and accelerate their training as fast as we can all of the way up through coaching to get them into the field quicker.

We recognize, I think, you're right. I don't have the data to say here's where we are right now. Many of the centers are still recruiting. Most of them are still recruiting and bringing people on board, so they have potentially a problem they'll have to overcome.

Rick Chapman – Kindred Healthcare – Chief Administrative Officer/CIO/EVP
One of the things this group might want to consider later is any way we can, in the form of policy or working with other groups within ONC, maybe begin to look at what I think is going to quickly become a problem, I think in general. That's this workforce issue related to adoption.

Ned Ellington – ONC – Director, HITRC Division
I think that what we're going to find is we will have people in the RECs that gravitate and they're really good project managers. They understand change management. They're great with people. They can manage multiple projects. I do think that people will recruit them. Our feeling is that's wonderful. I would love to give back and I would love to have a byproduct of the RECs training people that go on and be project managers in other places. It just does put a little bit of strain on us in developing an accelerated, boot camp type of training.

The advantage, again, of being in the REC is that there is this community of practice, so even though you're in the field you are not more than a couple of mouse clicks away from colleagues who have rich experience and are willing to help you. They're a phone call away if you want to go the traditional route. So that's the vision of how we might overcome some of that.

Marc Probst – Intermountain Healthcare – CIO
Any other questions for Ned?

Paul Egerman – eScription – CEO
How could our workgroup help you?

Ned Ellington – ONC – Director, HITRC Division
One area that is similar to what Melinda is saying is it would be wonderful to work with the workgroup to get input, ideas from the aggregation of the vendor community. I think that for us working with small offices the whole movement to cloud computing and cloud solutions is going to be a real opportunity. It's a growth area. Some vendors are moving directly. Some vendors are taking their solutions and putting them in the cloud, which has issues as well. So I think that understanding and being an opportunity to interact at that level would be fantastic.

I think, second, helping us shift maybe from an expert panel perspective and also to look at the data, look at the trends. Our vision is to have the data so we can substantiate anecdotal or not; we can actually have a little more empirical data. However, I know that in the extension business they're not data collectors. They're out there with a mission and they're going to be doing their mission, so we're going to need to be able to sit back sometimes and look at what's happening in the field through a different perspective and a different set of vendors so it can be helpful from a policy perspective. Those are the two areas to me.

Paul Egerman – eScription – CEO
That's .... One other question I have for you and possibly also for Melinda was one of the issues this workgroup addressed was issues related to patient safety, including patient safety related to the entire implementation and adoption process. Is that being addressed at all within the REC or within anything ONC is doing?

Ned Ellington – ONC – Director, HITRC Division
Well, from the OPAS, the Office of Provider Adoption Support, we also have our meaningful use team as part of our office, so making sure that people not only understand the rule of meaningful use, but also implement, particularly from a privacy and security and, I would include, a safety perspective. That's an ongoing part of our work. I guess what I'm saying is that we are building that safety into the meaningful use phase of helping in the implementation, so ....

Melinda Buntin – ONC – Director of Economic Analysis & Modeling
I'm not the best person to talk about this, but in the safety arena my understanding is that ONC's major initiative is that there will be an IOM panel that we're sponsoring—

Paul Egerman – eScription – CEO
Yes. I'm familiar with that.

Melinda Buntin – ONC – Director of Economic Analysis & Modeling
... the issues. Okay. Great.

Paul Egerman – eScription – CEO
So, getting back to this comment that Ned made about vendors and trying to understand how we could best help you there, would it be helpful to have some panel or even perhaps like a half-day hearing where we bring vendors in and we try to assimilate what their view points are on the entire process and what workforce problems they're having?

I was very interested in Rick's comment about project management. I think a lot of vendors would say that's where they're bottlenecks are for the workforce ... issue—

Ned Ellington – ONC – Director, HITRC Division

The other thing, in addition to those two, that I'm hearing is because of the market boom right now for EHR vendors, I'm hearing things like they're not being able to spend as much time and they're telling potential customers that they can't spend as much time on the implementation phase because of their backlog. So particularly when you get into the smaller operations where the RECs are targeted to support, what I would be interested in is what are the problems the vendors are having in their implementation that the local REC would be a logical, synergistic partner to go in and provide that. We're asking the RECs to be the project manager role to help the practices go through the traditional implementation approach and to be there to support them in that approach. But it's the handoff there. I predict that's going to be an interesting trade off and before you get into the urban areas and the smaller the practice then the more the problematic, potentially, it could be for the physicians.

Rick Chapman – Kindred Healthcare – Chief Administrative Officer/CIO/EVP

Well, Ned and, Paul, to your point, what Ned just said is the thing I fear the most if the vendors are pressed and for whatever reason this amount of time on how to do your job with the system is the most critical and the most timely and if we're speaking to eventual, meaningful use, which we are, the part that says the before and after, "Today you do your job this way and you achieve your contribution to what will eventually be meaningful use this way," and, "When using this system and a revised workflow, this is how you do your job." The concept of peer level education and training, and what I mean by that is clinician oriented and medical vocabulary oriented individuals, they have credibility with these various providers, are the most successful doing this, especially with physicians. In order for physicians to have their education and training in these they tend to want to do one-on-one and less groups and others, but this is the area that if we're going to need monitoring and feedback to make sure and workforce development to make sure this is happening because, if not, I'm predicting this is going to rise quickly to be one of our biggest barriers to successful attainment of meaningful use.

Ned Ellington – ONC – Director, HITRC Division

I mean ... on your point. You're exactly on target from my perspective. Here is a real example: My academic background is in strategy and technology implementation and so we know when you're doing transformation and you're able to demonstrate to that physician, to the nursing staff, to the admin staff this is what life is going to look like in the future and they can see themselves in that environment then that is a powerful driver for change, because they like it and they see it.

The problem is I'm looking for videos. Case studies are great, but a video, if you will, is a powerful tool. If we can say, "Here's what it is." If I don't have the testimony it's almost a TV show seeing them, so this is what life would be like. I'm having difficulty finding that. I know that many of the vendors have that and so how can we leverage some of that information and some of those tools at the local level? I mean, as you know, going to a two-physician practice and showing them a video about how a hospital is not persuasive. It's the ones where you have a two-physician practice. So that's an example.

Melinda Buntin – ONC – Director of Economic Analysis & Modeling

I would think that a hearing with vendors talking about their implementation experiences, problems they foresee, backlogs they're experiencing, what they think about the level of provider awareness around the incentive programs, things like that would be very valuable.

Joseph Heyman – AMA – Board Chairman

It might also be helpful to hear from physicians who are trying to implement and change their workflow about what they're experiences are.

M

Yes. I agree, Joe.

M
For sure.

M
That would be a good balance. I think we don't want to have a hearing that's solely vendor. You want to also have like vendor and user.

Ned Ellington – ONC – Director, HITRC Division
I think that would be excellent. Even in the physician I'd love to broaden it to their workforce needs because, as you know, we have the workforce programs going on where actually the REC Program and the community ... are connected to the communities of practice because I mean I envision some of the work the students doing internships and practices in small back offices because ... real quick, so I love that discussion of broader than just a workflow, but also just the same ability and what skills they really need in the offices.

M
I don't know if there are a couple of hearings there. I mean certainly, on the smaller physician offices and the requirements there from that set of vendors and those physicians and then I heard some broader topics around just overall the challenges the vendors are feeling and that may be a broader set of things or needs.

Ned Ellington – ONC – Director, HITRC Division
Yes. With respect to certification we're obviously aware of the certification procedures and things that are going to be happening. This is a question that I'm really sort of transferring from a different industry, but I'm concerned with a lot of small operations that have legacy EHR systems or existing EHR systems and they're going to be looking for guidance on what to do with those systems, particularly if those vendors are not some of the first few to be certified. I can imagine that we're going to be getting calls into the RECs of, —I don't need your help. I've got a good product, but what do you think about is this going to happen?"

So I think that whole certification and exposure of that and understanding—

M
When you say legacy what exactly do you mean? Do you mean me?

Ned Ellington – ONC – Director, HITRC Division
No. No. No.

M
Somebody who has the system already in place?

Ned Ellington – ONC – Director, HITRC Division
Yes. And your questions to your vendors are just going to be part of that.

M
Right, okay.

Ned Ellington – ONC – Director, HITRC Division

Of course, you're going to go to that vendor and the vendor is going to obviously be working on being certified, but when you look at this from a technology perspective, somebody asked Melinda earlier about modeling and what's happening in ... these are things that are transferable to our industry from other industries. Well, certainly in the area of technology and software there are examples of migrations in many different fields. I have no idea what's going to happen to the vendor community. I do know in other fields when we had 200 vendors in a particular software application area that was a large number of vendors and ultimately things migrated to a fewer number of vendors. That's a very turbulent time I would think that we're in and I'm sure there's nothing from the REC perspective we could do but sit back and observe that.

My concern is how do we help those physicians, who are caught up in that. Quite candidly, we've heard people say we're not going to worry about our selection until there are products that are certified. My concern on that is the bottleneck is going to get pushed further back and all of the sudden now we're going to have a lot less time to do the implementation.

M
Yes.

Ned Ellington – ONC – Director, HITRC Division
An exciting time, but a lot of issues.

Marc Probst – Intermountain Healthcare – CIO
Anything else to discuss with Ned or Melinda? Okay. Well, thank you very much. That was very, very helpful.

M
Yes, extremely helpful.

Ned Ellington – ONC – Director, HITRC Division
Well, like Melinda, if people want to have additional discussion I'm easy to get in touch with as well. Judy, thank you for inviting us.

Judy Sparrow – Office of the National Coordinator – Executive Director
You're welcome. Thank you, both.

Marc Probst – Intermountain Healthcare – CIO
I also do think, I mean, obviously, our workgroup is here to support this very engaged workgroup. I'd love to get the recommendation and get worked on, so if you have other ideas or thoughts where we can help that didn't come immediately to mind in this conversation, please reach out to us so that we can help.

M
I'll take you up on that and just launch some ideas out and let you guys respond to them ... ideas for ... it's making sure they're the right ones.

Marc Probst – Intermountain Healthcare – CIO
Okay. Great.

Ned Ellington – ONC – Director, HITRC Division
Thank you.

Melinda Buntin – ONC – Director of Economic Analysis & Modeling
Thank you. Our next topic was really to take and look at and prioritize what we will work on or what we think we should work on and start getting a game plan together so that we can do some of the things that Ned and Melinda just talked about and look at the areas of focus that were in the e-mail exchange that went out about three weeks ago.

I guess, Paul, you just want me to drive through these areas of focus?

Paul Egerman – eScription – CEO
Why don't you do that?

Marc Probst – Intermountain Healthcare – CIO
Okay. Again, thank you. Boy, some of you really put in some terrific input and I would not suggest that the area of focus or the way they are numbered within the document that was sent to you has very much meaning at all. The first four really represent what ONC got to us back and said those are areas that are kind of ripe for the workgroup to look at and the concern they had between 5 and 11 was exactly the conversation we just had. You've got groups like Ned and Melinda that have already kicked off some efforts or other efforts that might have been contracted out. So we did want to discuss those, because as you saw in the e-mail exchange, there was plenty to talk about in those categories. But really, the first four were the ones that initially ONC had said, "These could be pretty valuable to us."

So I'm just going to introduce the first area of focus and then hopefully have some comment amongst the group. I think we want to save time, based on what we just heard as well to see if there were some net new things; and I'm sure there were; that came out of that conversation.

Rick Chapman – Kindred Healthcare – Chief Administrative Officer/CIO/EVP
I certainly think that Melinda's area and her office can be very useful in my particular focus, which is the adoption challenges have been maybe trying to see from a policy standpoint can we best affect the overall success rate through addressing from a policy standpoint those barriers. I certainly would recommend that we coordinate very closely with that group to try to get any kind of questions or information that we deemed appropriate as a group included in her collection and analysis so we would have, I think, credible data from which to base our recommendations on.

Marc Probst – Intermountain Healthcare – CIO
I think that's great input, Rick. As I looked at her four areas, well, first of all, she called out that we can help around that modeling and as a workgroup either be presented to and provide expertise to it. Maybe we should address that first. Is that something we would like to do and something we should arrange with her or is that a subset of our group that would like to work on that?

Rick Chapman – Kindred Healthcare – Chief Administrative Officer/CIO/EVP
We certainly would participate. Larry and I have been talking about this over e-mail as well and it's something that either he or I both would be happy to attend.

Paul Egerman – eScription – CEO
It seems to me we're an advisory group and so it would seem to me very comfortable if there was a situation where she set up a phone call or a meeting or something where she said, "Here's what my modeling is. What do you think?" and we just had open discussion. I think it would be helpful to her, some format like that. It's up to her.

Marc Probst – Intermountain Healthcare – CIO

Yes. It sounded, Paul, like they were going to hold a physical hearing on this. I, for one, would be very interested in that—

Paul Egerman – eScription – CEO
Sure.

Marc Probst – Intermountain Healthcare – CIO
And I think Rick and Larry. I just didn't know how the rest of the workgroup felt or—

M
Absolutely.

Marc Probst – Intermountain Healthcare – CIO
We'll make it an open invitation to the workgroup if she'd like to and those that can make it get there I guess.

The other area was; she had four areas that she focused on, the data collection, the modeling, the supporting and encouraging adoption and then ONC performance. As I went through that where I really felt like we could really help and understand and become kind of an area for bouncing off on those first two, but the supporting and encouraging adoption sure felt like something based on all of the e-mail exchanges and conversations we've had in the past we might be able to provide more support.

Rick Chapman – Kindred Healthcare – Chief Administrative Officer/CIO/EVP
Yes, Marc, I thought so too. On this first point in the communications you sent out about getting the EMR naysayers to the table; I'm just a little bit almost outside of our scope, so I might be in disagreement with some of the others, because this is more like how to affect hearts and minds. While I agree it's an issue, it seems to be more toward her third bullet, which is more of a communications and marketing campaign, which I certainly think we need, a PR campaign to try to overcome some of these either real or perceived issues.

So on that third point, if we agree we're going to adopt number one as one of our committee challenges or workgroup challenges, I think we should at least coordinate with her in that effort, because it sounded like that's something her office was charged with.

Marc Probst – Intermountain Healthcare – CIO
Yes. That's well put. You know, as I look through that recommendation I kind of saw, I mean Joan and Larry and Joe have all responded to that and maybe some others, but my sense was it's broader than just naysayers. It's what are the issues that are out there. Because they're naysayers for a reason and it's really ruling out what those reasons are versus trying to convince them to suddenly adopt EHR. That opens up this topic area, so should we talk about this first recommendation or area of focus?

M
Sure.

Marc Probst – Intermountain Healthcare – CIO
Joe Heyman, you had some pretty good comments on it.

Joseph Heyman – AMA – Board Chairman
Well, I guess I'm thinking to myself that first comment I made was about rather than just concentrating on the naysayers when I look at those who represent those most typically finding difficulty in adoption. I

think that rather than the naysayers those folks are not going to adopt, so it seems to me we ought to be looking at people, who would like to adopt, but can't or are having difficulty in doing so and understanding that rather than the people who are just in the dark ages.

Marc Probst – Intermountain Healthcare – CIO
That's a good point. Other thoughts on this one?

M
It is a good point. It's interesting because it's sort of related to the concept of perhaps having a hearing or something with vendors in terms of understanding where the backlogs are. It's sort of like maybe there are a lot of people who really wanted to adopt, but they're afraid to. They don't know how to start or they want to start, but they're frustrated. It takes six months to get their contract done.

Joan Ash – Oregon Health & Science University – Associate Professor
I think it's usually really valuable to hear from the ... or the skeptics and maybe we need to think about a way of hearing from them, whether it's a hearing or I know we talked about surveys and we're stymied in doing surveys because of this Paperwork Reduction Act, I'm afraid. So really, the only way we can get input is through a hearing. I wouldn't write-off the skeptics from the list. I think that we should hear from people, who have not adopted and will not adopt because they thought deeply about the issues.

Rick Chapman – Kindred Healthcare – Chief Administrative Officer/CIO/EVP
Joan, I think you're on to something here. Maybe what we can do and I think, Joe and Paul, I agree with you from our focus is one thing, but the fact that Melinda wrote up that they have this arm of her department who is prepared to deal with this issue, maybe Joan is right. Maybe we would host hearings to try to get to some of the areas that we need to address and then that would serve to inform Melinda's group to actually go off and target to work on them. In the meanwhile we can work on the barriers as well.

Joan Ash – Oregon Health & Science University – Associate Professor
I'm trying really hard to see where another initiative of ONCs that I'm working on on the unintended consequences of HIT, where this fits in and whether some sort of link between that initiative and this workgroup might not be really, really valuable so that if we working on the unintended consequences of HIT contract could call on the members of this workgroup for input that would be really, really valuable.

M
I think you're right, again, because I don't intend any consequence eventually turns into a barrier.

Joan Ash – Oregon Health & Science University – Associate Professor
Right.

M
Interesting.

Marc Probst – Intermountain Healthcare – CIO
Yes that is. Does this particular area of focus or hearing or however we focus on it, we probably should figure out how we're going to do that. It's sounding like a hearing. I mean is it really kind of going back to that whole concept of barriers?

M
I think it's up to us to structure it, Marc. I think it could and we'll have to decide how big is too big, but you certainly could have the people come in and talk about the various aspects of resistance that we're

hearing and that could be either from the naysayers or we could structure the panels to be such that we could also hear from those who are trying to adopt, but for one reason or another find themselves unable to.

Marc Probst – Intermountain Healthcare – CIO
So that becomes kind of fodder for a potential PR campaign.

M
Right. That's why I was thinking maybe certainly this would be the information we can collect from this hearing would certainly be great input to Melinda's group because they're charged with, I think, coming up with the campaign materials and the communication materials. It sounds like she's done a lot of it with HIMSS and others trying to spread the word, so maybe this is input to them.

Marc Probst – Intermountain Healthcare – CIO
Also, you know, I guess there are three kinds of people who can discuss barriers, who are people who've actually; within the physician community I'm talking about right now. One is the naysayers. One is the group of people, who would like to adopt, but have concerns. One is the people who have adopted and can tell you what the problems where along the way. So it seems to me if we were going to have a hearing about that you'd want to have a little of all three of those.

M
Well, I certainly agree. Maybe you're right, Marc, maybe the overall theme should be barriers and it should include both, naysayers and others along the lines Joe is thinking about and then try to get the various use scenarios that we want to make sure were represented.

Marc Probst – Intermountain Healthcare – CIO
Does this engage the vendors at all? Should it or is this really focused on those people that are trying to implement it from a user perspective, and primarily physicians from what I can tell?

Paul Egerman – eScription – CEO
I think if you define the concept of barriers it does involve the vendors, because if the vendors have backlogs the vendors can't get their product certified because of the certification backlog. If they can't hire enough people that have project management experience those are barriers.

Rick Chapman – Kindred Healthcare – Chief Administrative Officer/CIO/EVP
I agree, Paul. I think we need to structure this that we have both, users and vendors as different panel groups, just like we did with the safety and other hearings. If we could think through that a little bit we could probably get a wealth of information and a long day, but along this line. I think that potentially if we can do some of that information gathering in these forums it might give us the kind of data we need then to formulate as we go along here what might be areas of policy that we need to improve to help with adoption.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I think you have to be very specific about what they're saying nay to. There is the program. There's meaningful use. There are quality measures, so it's specifically adoption. We don't want to create a platform for people to come and complain about other things that were not really going to help us improve the rule.

Rick Chapman – Kindred Healthcare – Chief Administrative Officer/CIO/EVP

Well I think, George, we were focused on the concept of barriers to adoption and we'd have to maybe define it better, but at least that's what I was thinking in terms of our discussion.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Adoption of the technology?

Rick Chapman – Kindred Healthcare – Chief Administrative Officer/CIO/EVP
Yes. Adoption of certified health information technology EHRs, which is in totality the technology.

M
Do we want to hear, for example, that it's not worth the money? That it costs too much? We want to hear that it costs too much. We don't want to hear that it's not worth the benefit. Even with adoption the question is why didn't you try to adopt this complex? It's also someone who tried to adopt, had a problem and failed. That, I think, is very well focused.

Rick Chapman – Kindred Healthcare – Chief Administrative Officer/CIO/EVP
Well, that was the whole question. That was Joan's comment and up for us to debate is should we deal with just pure naysayers or, as Joe suggested, should we just go straight to those who at least are trying?

Marc Probst – Intermountain Healthcare – CIO
Well, right. In fact, earlier in the e-mail we talked about the ones who did it and succeeded, but had problems along the way, we just said again, and the ones who tried and failed. It's the naysayers where you have to be the most careful. But we were saying that we should include some of that, right? That's one third or whatever the proportion.

M
I like the three categories Joe Heyman put on the table. You definitely want to hear from the naysayers.

M
But the naysayers on how hard it is to adopt as opposed to other naysayers.

M
Or why they became naysayers, which is, I think what Joan was getting to.

Marc Probst – Intermountain Healthcare – CIO
I know. Right. As long as it's clear to them or we're going to be picking the people, so I guess we'll be okay.

M
Yes.

Joan Ash – Oregon Health & Science University – Associate Professor
Maybe we should think of them as thoughtful non-adopters.

M
Well, but I don't want to hear they didn't adopt because they don't believe in giving incentives to doctors or something. There are lots of reasons why you might not do it other than adoption issues.

Marc Probst – Intermountain Healthcare – CIO

Well, maybe ONC can help us craft the language and as we select the participants and the language of the topics we want and the scope of the discussion such that we could at least minimize any of the issue that you're referring to. Basically, letting the discussion be just a griping type of session.

M
Right. Exactly.

M
Yes. And it shouldn't be political. I think Joe Heyman said this as well. I mean we're really looking at the adoption of the technology. If you've got a political belief or—

M
Exactly.

M
The technology sucks, well tough. That's not what we're talking about.

Joseph Heyman – AMA – Board Chairman
To me it seems the most important thing is I think most people believe that this technology is going to be in effect within some certain period of time and that people would like to adopt it if they could do it without it being too much of a chore. I think if we can put our finger on what makes it a chore and what can be done about that. I think that would be very helpful.

You know, even listening to the conversation we just had, the conversation about if you can give somebody a vision about what their workflow might look like, I even worry about that as a barrier because I think to myself you give them a vision and they look at that workflow and they think to themselves, "Oh my, God, that's the reason I went into solo practice in the first place. I wanted to avoid that workflow." So I think even there part of the job of these regional extension centers should, rather than telling the doctor how the workflow should be, should be considering what kind of workflow they would have preferred to the one they have and whether they can achieve that using technology. Even that, I mean that's the kind of thing I would hope we would hear.

Paul Egerman – eScription – CEO
Joe, those are good comments. So I'm trying to understand how to sort of like summarize this. It sort of says I look at the four areas of focus that was in the original memo and if I'm hearing this right we're saying instead of what's under number one about naysayers and instead of number three about adoption challenges we're going to look at a category that we're going to call barriers to adoption. Am I understanding that correctly from this discussion?

Rick Chapman – Kindred Healthcare – Chief Administrative Officer/CIO/EVP
I certainly like that.

Paul Egerman – eScription – CEO
Okay. So we're going to call it barriers to adoption and we're looking at the entire cycle, including—

Rick Chapman – Kindred Healthcare – Chief Administrative Officer/CIO/EVP
But rather than just looking at the barriers, I mean I'd like to hear from somebody about how we can address those barriers.

Paul Egerman – eScription – CEO

Well, that was the question I had. Are we only identifying barriers? When you identify a barrier you would say something like there are not enough project managers and people or you would say, to speak to the most recent topic you'd say physicians can't understand how to change their workflow. So that would be described as a barrier. Or are we going to say there is a barrier and here's what has to happen? You need to do the following things.

M
We certainly could follow on; that's a good point; as we have with these other hearings, you know? In the early part of the day we could talk about the issues and the barriers and in the latter part of the hearing we could also hear from people who have successfully overcome these barriers.

Paul Egerman – eScription – CEO
True.

M
Yes. That group that Joe lined up, those who have adopted and experienced kind of the hard knocks, that was pretty interesting.

M
Yes. It's one of these things; to identify the problems, identify the barriers is something important to do, but it's an easier job than trying to figure out how to solve—

M
Exactly.

M
I suppose what we're supposed to do is we're supposed to the harder thing, so we should probably look at those issues too.

M
Embedded in Rick's comments I heard perhaps we can be looking for models of success. Joe was talking about, one, to make sure that the docs actually get their vision of how they want to provide healthcare blended with using this technology. So in the same way ... we can talk about models of success where it's plural, models, that there's more than one way to get this right. There's not just one way to use the computer system.

Paul Egerman – eScription – CEO
That's right. Although, I think we have to make sure that we limit ourselves to like stage one is meaningful use.

M
Yes.

Paul Egerman – eScription – CEO
Because otherwise I mean I think people have written a lot of stuff already about how to install these systems. We don't need to be repeating some of those issues. The issue is stage one and meaningful use. What are the barriers?

M

Yes. I think that's true, Paul. It's going to be hard to limit it to meaningful use though. I think the barriers, the way meaningful use is defined it's a series of objectives or functions that need to be accomplished, but there are going to be barriers that aren't implicit in meaningful use, just in general implementation of the products I would think.

M
That's true. That's true.

Rick Chapman – Kindred Healthcare – Chief Administrative Officer/CIO/EVP
One of the issues; this is Rick again; that we're going to have to deal with here that's in the middle of both of your comments is that a big assumption has been made by our collective work groups and that is we made the assumption that if one can install a certified system and achieve the proper utilization rate of some key functionality that then they will achieve meaningful use and the implementation and adoption process really is the way to get there.

M
Right. So the issue is when we're talking about barriers are we talking about barriers to install electronic health records or are we talking about barriers to achieving meaningful use or are we talking about barriers to qualify for the stage one incentive?

M
I would think that we want to focus on the implementation and adoption first. The others are both good questions. I'm afraid that our meaningful use workgroup will want to focus on the second though.

M
So we're focused on implementation adoption?

M
Right. Assuming that if one can achieve successfully that part of the process, which is to install, successfully install, and begin utilization of the systems that then we will come along and with the meaningful use workgroup I think they're going to quickly turn their focus to how people can use these systems to achieve meaningful use.

M
Okay.

M
I mean that's just my opinion.

M
I think it's a good opinion.

Joseph Heyman – AMA – Board Chairman
It makes sense to me.

Marc Probst – Intermountain Healthcare – CIO
Okay. Should we summarize what we just said or not?

Joseph Heyman – AMA – Board Chairman
I'm sorry. Say that again, Marc.

Marc Probst – Intermountain Healthcare – CIO
Are you in a position to summarize what we just said?

Joseph Heyman – AMA – Board Chairman
Am I in a position?

Marc Probst – Intermountain Healthcare – CIO
Yes. I mean I can do it if you want.

Joseph Heyman – AMA – Board Chairman
Why don't you try to do that?

Marc Probst – Intermountain Healthcare – CIO
Oh, …. I knew you'd say that. Well, let me ask a question first—

Joseph Heyman – AMA – Board Chairman
Before you summarize I want to just say something—

Marc Probst – Intermountain Healthcare – CIO
All right.

Joseph Heyman – AMA – Board Chairman
But you can ask the question first because maybe it's the question.

Marc Probst – Intermountain Healthcare – CIO
No. No. You go. You go, Joe.

Joseph Heyman – AMA – Board Chairman
Well, I just want to say are we expecting physicians to want to adopt this because of the meaningful use criteria? I mean to me I would hope that there would be a vision that could be presented to physicians that would make them excited about doing this rather than the vision of being able to meet certain criteria.

Marc Probst – Intermountain Healthcare – CIO
But you know what's interesting about how we define that, Joe, is if we're focusing on barriers we're sort of focusing on the negative ... but the way your comment would come across would be to the extent that we got input that physicians don't see the value. They don't understand. They don't see the value in this approach, in the meaningful use or in implementing these systems.

Joan Ash – Oregon Health & Science University – Associate Professor
In a way it's the whole objective managing expectations so that we're not thinking negative or positive, but just what the tradeoffs might be?

M
I think that's correct, although I'm not sure I'd say it's managing expectations. Part of it is understanding it.

Joan Ash – Oregon Health & Science University – Associate Professor
Understanding. Well—

M

Understanding where we are right now so we can make some recommendations as to where we need to be.

Marc Probst – Intermountain Healthcare – CIO
So why don't I try and go through this? I'm sure I've got it wrong, but I'm also sure you guys will correct me.

M
You didn't forget the question, did you?

Marc Probst – Intermountain Healthcare – CIO
The question comes at the end I decided and I wrote it down or yes I would have. We're looking at putting together a hearing that would include primarily users in the physician community. I'm not hearing a lot of on hospitals, but again, you can correct that. Vendors … products that would serve that community. Really, the three areas that we'd like to focus on or the types of people we'd like to have there are thoughtful non-adopters, a.k.a., naysayers; those that would like to adopt, but have legitimate concerns about doing so; and those who have adopted and have really experienced some hard knocks.

From that we'd like to elicit barriers to adoption of the technology. We'd like to understand lessons learned or, I guess, tips and techniques for doing it better and improving the ability of these folks to implement the systems, all to create some recommendations to ONC on how they can help improve this adoption process, either through PR or however. I don't know how we're going to do it, what the actual recommendation is.

Paul Egerman – eScription – CEO
Let me just raise a concern about what you just said. I think what you might end up with is naysayers who are from very small practices and people who successfully adopted from very large practices. I think we should be careful to try to have small and medium size practices at the biggest in all three groups so that we don't end up with the usual situation of everybody has to model themselves after huge systems.

Marc Probst – Intermountain Healthcare – CIO
I think that's great, Paul.

M
That's a good point. It also sounds like; I wasn't sure this is what you said in your summary, Marc. It sounds like this hearing is really only on the physician side. We're not dealing with hospitals.

Joan Ash – Oregon Health & Science University – Associate Professor
Well this is Joan and I wanted to ask why not. Just because there are small hospitals out there too and for them there are barriers just as great as for the physicians. I know physicians are in communities where those are the hospitals that are going to be having those problems.

M
So another way you can cut it would be to say you'll do small hospitals and small physician groups.

M
Why wouldn't we consider maybe doing physicians in one hearing or one day of a hearing and hospitals, both small, rural and other, at another hearing only just to break it up because it's a large and different audience?

M
Yes. I assume we think the issue is the reason for doing that also is the assumption that the issues will be different.

M
I think so.

M
I think they will be.

M
Yes. I agree. I think there will be some commonality, but I think, especially in some workforce issues that I think they will be very different issues.

Marc Probst – Intermountain Healthcare – CIO
That was really good input, both on focusing on the smaller groups because what you'll get is partners or Intermountain or something like that—

M
Exactly. We always get those.

Marc Probst – Intermountain Healthcare – CIO
Yes, exactly. Although I like hearing that it's still not representative of what we should do.

M
It's not somebody who's actually had to make a living in a small employment situation and roll out this technology at the same time. It's a completely different situation and there's absolutely no recognition of that in many instances where you hear from the larger entities.

Marc Probst – Intermountain Healthcare – CIO
That's great. So I do like that structure of whether it's two hearings or two days. We could structure that with ONC and I'm sure they could help with that.

What kind of timing do you think we need on this? I mean meaningful use just came out. Certification just came out. So I mean I don't think there is a too soon date, but there are also logistics and things that have to happen. What kind of timing would you guys see on this hearing?

M
Gee. I think the problem we're going to have is getting panelists and people to come here during the vacation season, so this is probably going to have to be at the end of the summer or early fall. I mean if we could do it sooner, great, but I don't know how we're going to be able to pull it off.

M
Yes. I would take a guess at September or October.

Marc Probst – Intermountain Healthcare – CIO
Is that soon enough do you think for—?

M
I do. I think there's got to be a time for digesting what they just released.

Marc Probst – Intermountain Healthcare – CIO
Okay. So September or October. We'll go with that. Obviously, we've got to work this through with ONC, but this will be very helpful.

Paul Egerman – eScription – CEO
In one sense we've got to look at this hearing as sort of an event in terms of an understanding of how this workgroup is going to operate going forward. What we're also saying in terms of these areas of focus is there's an area of focus that we're going to look at. We're going to try to understand where are the barriers, where are the bottlenecks in the entire process and try and gather information and suggestions to help ONC on the adoption side. Is that a fair summary of what we're saying?

M
Yes.

Paul Egerman – eScription – CEO
Okay. So to also return to the four areas of focus, it seems like what we just said there, looking at the e-mail, combines what was written for number one and for number three into a single concept. I'm wondering if we shouldn't walk through the others too and coordinate with the implementation workgroup. Is that something people wanted to talk about at all?

Marc Probst – Intermountain Healthcare – CIO
Just a note to ourselves: We have about 20 minutes.

Paul Egerman – eScription – CEO
Okay. I agree with you, Paul. I mean is anybody passionate about number two?

M
I'm sorry. I'm running back to number two.

Judy Sparrow – Office of the National Coordinator – Executive Director
Just so you know too, the Implementation Workgroup, that's under the Standards Committee and it's chaired by Aneesh Chopra. It's gone on a little bit of a hiatus. He's been concentrating on this Enrollment Workgroup, so that just might be moved.

Marc Probst – Intermountain Healthcare – CIO
I wrote a note next to that particular bullet that said maybe we should get a call with Aneesh and that workgroup and more coordinate how we can help versus trying to do it on a—

Paul Egerman – eScription – CEO
I think that's a good idea.

Judy Sparrow – Office of the National Coordinator – Executive Director
That's a good idea.

Paul Egerman – eScription – CEO
For now we just leave it on the list though.

Marc Probst – Intermountain Healthcare – CIO

Leave it on the list and coordinate that call. If Aneesh is really focused on that whole enrollment thing they're probably stalled for a little bit. My sense was I didn't get a whole lot of enthusiasm around number two, even from e-mail exchange.

Paul Egerman – eScription – CEO
Okay.

Marc Probst – Intermountain Healthcare – CIO
All right. Number three is what we're doing.

Paul Egerman – eScription – CEO
Yes. We combined that with the new number one.

Marc Probst – Intermountain Healthcare – CIO
So, four is monitor the certification process looking at effectiveness. I think that's got to happen, Paul.

Paul Egerman – eScription – CEO
Yes, not only has it got to happen; I thought part of our original charge was we were supposed to do a report like every six months. I mean if it's not part of our original charge it would be a reasonable thing for us to do just every six months give some assessment of what we think about it and also to try to reach into the vendor community and into the certification community and figure out what recommendations might be made to improve that process. I mean I don't think we can necessarily claim that we or ONC got it right the first time. There's got to be things that can be done to improve things.

Marc Probst – Intermountain Healthcare – CIO
I agree with you. I think we do need to put a similar process around either hearings with the vendors and the certification groups to strive to do that and to report back to ONC unless someone else is taking up that banner. I thought it was part of our charge.

Paul Egerman – eScription – CEO
Yes. If we do the first hearing in, like we say, the September time frame, maybe the right thing to do is to either do a hearing or some other process on certification, maybe three or four months later, say like November or December. The reason for that is then the certification process will have been in place for four or five months and there will be data that we can start to gather from it.

Marc Probst – Intermountain Healthcare – CIO
Yes. And, Paul, it might help for us to have a similar phone call as today, but with the folks responsible for certification. So what have they already gone out and contracted—

Paul Egerman – eScription – CEO
Right.

Marc Probst – Intermountain Healthcare – CIO
And monitoring it, those kinds of things. I thought Melinda and Ned were very helpful. If we could get that set up, Judy, where we can have this kind of a phone call, conference call and ask them questions that might help us focus on what that hearing would look like. I think that's right, Paul. I'm looking at the November/December time frame.

Judy Sparrow – Office of the National Coordinator – Executive Director
Okay. I'll talk to them and get something set up.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Does anyone remember what the timeline is for the permanent certification process? Doesn't that, in a sense, kick off this fall?

Judy Sparrow – Office of the National Coordinator – Executive Director
Yes, I think it does. I can't remember which month though.

M
Larry, are you saying—?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
There's going to be an updated ONC rule for the permanent process, so—

Judy Sparrow – Office of the National Coordinator – Executive Director
Maybe that was December. Let me find out and get back to you all.

M
Well, there's the issue of the updated rule, but there's the issue also of when it actually starts. The permanent process, if I remember right, doesn't start until the end of 2011 or 2012.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Right, but there was a rule going to come out on defining the permanent process I think this fall. I thought we made –

M
Yes. I think they didn't do the rule yesterday ... rule on it soon. My guess is the rule on the permanent process is going to be pretty much the same as what they did on the temporary process, which they did finish. But our effort is really sort of like similar to what we did on adoption. Our effort is to say does this thing work and write it. What do people like and what do people don't like about it?

M
That's one thing. Can we make a recommendation ahead of the rule coming out if there's enough feedback from the temporary process?

M
Oh, I see. My guess is not. I don't think there will be time. First, my guess is we won't have time and secondly, the way the process works we really can't, right? The time period for making comments and recommendations under the permanent rule has passed.

Marc Probst – Intermountain Healthcare – CIO
Okay. So our approach on number four would be let's get a phone call similar to this one, understanding where they're at, understanding what steps they're taking. We don't know with consultants and other things. Then at the end of it we'll again assess what we think we could accomplish in a hearing later this year in moving this forward or other processes that you suggested, Paul, later on this year, but we really need to have that conversation with the group focused on certification.

Paul Egerman – eScription – CEO
Yes, we need to have that conversation with the group and I think, as just sort of instinctively I think we all know we also need the certification process to be put into place. I know we have some track record to work with and that's why it's so later in 2010 or possibly even early 2011 before we can do very much with it.

Marc Probst – Intermountain Healthcare – CIO
We want everything, huh? We have 15 minutes left and we have 5 through 11 and we also heard things in the presentations from Ned and Melinda earlier. So what I see in here, Paul, is a presentation we'll give to the Policy Committee next week when we all meet, talking about our next steps. I see three right now. One is the hearing we put together on, I'll just call it naysayers; we won't in the presentation. Number two; that we're going to coordinate with Aneesh and his team. Number three; we're going to get a phone conversation around the certification and what's going on actually within ONC on that and then we'll put our plans together there.

What else would we like to put on that presentation we'll give to the Policy Committee based on 5 through 11 or what we heard today in the conversation?

Paul Egerman – eScription – CEO
One thing that I heard today is sort of like number four, it's like informal advisors to the ONC staff. We could comment on their metrics so that we can answer questions that they pose and even provide them feedback informally from vendor communities in situations where they can't necessarily do surveys so we can give them our impressions of things. I still think that's a valuable function for us to perform.

M
I think a lot of 5 through 11 are going to be addressed in our new topic of addressing barriers and that out of those barrier hearings could come other focus, but I think we encompassed a bunch of the other bullets in our earlier discussion.

M
I agree. There are like two issues. One issue that I thought of after the rule came out yesterday, I was impressed that the rule seemed to respond to our comments about the administrative simplicity. An area that I wish CMS would deal with is like the personal thing of .... I really hate all of this self attestation stuff. It troubles me that these things are not administratively simpler to do. It would seem to me an interesting area that we could perhaps do.

Perhaps there's an expansion of our certification to look at a process where there's a physician or a hospital who buys one of these things. Somehow there's a registration process, like registering a car. So through that process you sort of register it with CMS and so you get rid of the idea that you do any attestation as to whether or not the person really owns the system and that part of this process is we make sure that somehow stage two and stage three criteria are such that whatever you need for metrics to qualify are produced automatically by the system themselves so that people don't have to fill out forms or do any self attestation. I mean ideally it would be great if the system did it all for you, for the user and even electronically submitted it to CMS. I call that administrative simplicity. Is that something people think would be valuable for us to address or is that just sort of one of these boring topics?

M
I think we did address it, didn't we, when we made our recommendations? Am I thinking of something else?

M
No, we didn't address it. We didn't address the registration process for certification. Maybe we should just address it. If we want to do that we can do that as part of our monitoring process.

M
Yes. Because I think we could get a little better understanding where ONC's head is around that as well.

M
Okay. That sounds fine.

Judy Sparrow – Office of the National Coordinator – Executive Director
We need to think about the public comments now too.

Paul Egerman – eScription – CEO
Any last comments from the workgroup though before we go to public comment?

Joseph Heyman – AMA – Board Chairman
Do you want to write-off number 11?

Paul Egerman – eScription – CEO
I don't.

M
I don't either, but that's one of these hot buttons that everybody is looking at.

Joseph Heyman – AMA – Board Chairman
Okay. Well, that's fine. I just wanted to make sure we didn't just ignore it.

M
Why don't I leave, so we've got one through four that we put together that we'll present? I'll aggregate a few of these that do fall outside of hearing number one and we'll just keep them on the ticker ... because I think that's an important one, Joe.

Joseph Heyman – AMA – Board Chairman
Okay.

M
... okay, Judy.

Judy Sparrow – Office of the National Coordinator – Executive Director
Great. Thank you. Good discussion. Operator, can you see, please, if there's any public comment?

I don't think we have another call set up or do we, Marc or Paul?

Marc Probst – Intermountain Healthcare – CIO
I'm not aware of one.

Paul Egerman – eScription – CEO
I'm not aware of one. I think what we need to do is let's do this for the next call. Marc and I need to put together our recommendations for the Policy Committee. We'll take whatever feedback we get from the committee on them and then based on that we'll set up our schedule.

Judy Sparrow – Office of the National Coordinator – Executive Director
Operator, any public comments?

Operator
We do not have any comments at this time.

Judy Sparrow – Office of the National Coordinator – Executive Director
Okay. Thank you, Paul and Marc, very much.

Paul Egerman – eScription – CEO
Okay.

Marc Probst – Intermountain Healthcare – CIO
Paul, I'll get back with you on getting prepared for next week.

Paul Egerman – eScription – CEO
Yes. As usual, and as always, thank you very much, Judy, for all of your help in organizing this. Thank you to all of the members of the workgroup team who show such dedication on a beautiful day in July to be involved with our call. Thank you so much.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you. Good-bye.

Paul Egerman – eScription – CEO
Good-bye, everybody.